

**MATERNAL, CHILD AND ADOLESCENT HEALTH DIVISION
COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)
PROVIDER APPLICATION**

IMPORTANT: Read the instructions on pages 4 and 5 thoroughly before completing this application.

Submit the completed application to your local Perinatal Services Coordinator (PSC). Retain a copy for your records.

FOR STATE USE ONLY
DATE RECEIVED: _____
EFFECTIVE DATE: _____
STATE CONTROL #: _____

1. MEDI-CAL PROVIDER TYPE

- | | | |
|--|---|---|
| <input type="checkbox"/> Solo Provider | <input type="checkbox"/> Group Provider | <input type="checkbox"/> Clinic (county, community, hospital outpatient) |
| <input type="checkbox"/> FOHC/RHC/IHC | <input type="checkbox"/> Alternative Birth Center | <input type="checkbox"/> Check this box if applicant is a Certified Nurse Midwife (CNM) |

2. PROVIDER INFORMATION

Legal Name of Applicant			National Provider Identifier (NPI)	
DBA (if applicable)			Phone Number	
Service Address	City	State	ZIP Code	
Pay-To Address	City	State	ZIP Code	
Mailing Address (if different from Service Address; must match applicant's Medi-Cal record)	City	State	ZIP Code	
Contact Person	Contact's Phone Number	Contact's Email Address		

3. SUPERVISION

Supervising Physician	Supervising Physician's Email Address	License Number
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4. CPSP PRACTITIONERS

(A) PRACTITIONER NAME	(B) CPSP PRACTITIONER TYPE (MD/DO, CNM, NP, PA, LM, RN, LVN, SW, PSY, MFT, RD, HE, CCE, CPHW)	(C) PRACTITIONER QUALIFICATIONS	(D) SERVICE(S) PROVIDED*										(E) YRS OF EXP.	
			OB	B	CO	HE	N	PSY	CC	CON	P			
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:												
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:												
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:												
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:												

4. CPSP PRACTITIONERS (continued)

(A) PRACTITIONER NAME	(B) CPSP PRACTITIONER TYPE (MD/DO, CNM, NP, PA, LM, RN, LVN, SW, PSY, MFT, RD, HE, CCE, CPHW)	(C) PRACTITIONER QUALIFICATIONS	(D) SERVICE(S) PROVIDED*								(E) YRS OF EXP.	
			OB	B	CO	HE	N	PSY	CC	CON		P
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:										
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:										
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:										
		LIC/CERT/REG#: SCHOOL: DEGREE: YEAR:										

- * OB = Obstetrics/Gynecology B = Back-Up Physician CO = Client Orientation
- HE = Health Education N = Nutrition PSY = Psychosocial
- CC = Case Coordination CON = Consultation P = Protocol Approval
- Check here if using hospitalist/laborist group for deliveries. Provide the name of the group:
- See attached CDPH 4448a for additional practitioners

5. PROTOCOLS

- DEVELOPING NEW PROTOCOLS** (include the names of the qualified health education, nutrition, and psychosocial consultants in Section 4: CPSP Practitioners)
- USING PREVIOUSLY APPROVED PROTOCOLS** (identify protocols below)

NAME OF PROTOCOL AND YEAR OF APPROVAL

NAME OF PERSON RESPONSIBLE FOR CUSTOMIZING PROTOCOLS FOR THIS SITE

6. CPSP PROVIDER OVERVIEW TRAINING

STAFF NAME	TITLE OF TRAINING	DATE TRAINING ATTENDED	PLANNED/SCHEDULED TRAINING DATE

7. ATTACHMENTS

Note: all documents below will be kept on file at the local PSC's office.

- I. Prenatal Medical Record Form(s):** Attach a blank sample prenatal medical records form(s).
- II. Nutrition, Psychosocial, and Health Education Assessment Tools:** Nutrition, psychosocial, and health education documents for initial assessment, trimester reassessments, and postpartum assessments.
- III. Individualized Care Plan:** Includes obstetric, nutrition, psychosocial, and health education components.
- IV. General Description of Practice:** A description of how the practice, clinic, and/or organization will provide CPSP services for the obstetric, nutrition, psychosocial, and health education components. In your description, please include high risk and emergency patient care.
- V. List of Delivery Hospitals:** The name(s) and address(es) of the hospital(s) at which deliveries are planned to take place.
- VI. List of Referral Services:** The name(s), address(es), and phone number(s) of the person(s) and agency(ies) to whom you will refer for OB and non-OB care, well-child pediatric care (e.g., CHDP), family planning services, Supplemental Nutrition Program for Women, Infants, and Children (WIC) services, genetic services, and dental services.
- VII. Antepartum/Intrapartum/Postpartum and Dual Provider Model Agreements:** If a person or entity other than the applicant will be responsible for providing and billing services for antepartum, intrapartum, and/or postpartum obstetrical care, the applicant must attach a written agreement(s) to this application. The agreement(s) must describe the relationship and specific responsibilities of the applicant and the obstetric care provider(s), including the flow of patient services and patient information between all providers. It should include the name(s) of the delivery hospital(s) where obstetric provider has privileges, how emergency services will be provided, and billing responsibilities.

8. DELIVERIES

Number of deliveries in the last 12 months:

Number of Medi-Cal deliveries in last 12 months:

9. AUTHORIZATION

I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to receive enhanced Medi-Cal reimbursement for CPSP services and that I must report changes to the above information to the local Perinatal Services Coordinator (PSC). CPSP providers are subject to disenrollment for failure to adhere to program policies and administrative practices. Onsite visits and attempts at corrective action may be made prior to disenrollment.

APPLICANT OR AUTHORIZED AGENT'S PRINTED NAME & TITLE

APPLICANT OR AUTHORIZED AGENT'S SIGNATURE

DATE

All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government code, Section 6250 ET SEQ.

FOR LOCAL HEALTH JURISDICTION (LHJ) USE ONLY						
ACTIONS TAKEN ON APPLICATION			CPSP PSC'S RECOMMENDATION TO CDPH			
Date	Action	Initial	Deferred	Recommended	→	Approval Effective Date:
	PSC received application					
	Returned for additional information					
	Application resubmitted					
	Returned for additional information					
	Application resubmitted					
			Local Agency Name:			
			PSC Name & Title:			
			PSC Signature:			
			Signature Date:			

INSTRUCTIONS FOR COMPLETING THE APPLICATION TO PARTICIPATE IN THE COMPREHENSIVE PERINATAL SERVICES PROGRAM

- **Contact your local Perinatal Services Coordinator (PSC)** prior to completing the CPSP application. For a list of PSCs, visit the CPSP website (<http://cdph.ca.gov/cpsp>).
- Print or type all information so it is legible. Use black or blue ink only. Do not use pencil.
- Review Title 22 [CPSP regulations](#).
- Complete a separate application for each service site. Application processing may be delayed if the information provided on the application does not match the information in the applicant's Medi-Cal record.
- Submit the completed application to your local PSC.

1. **MEDI-CAL PROVIDER TYPE:** Check the box that corresponds to the provider type listed on the applicant's Medi-Cal application – solo, group, clinic (county, community, hospital), FQHC/RHC/IHC, alternative birth center. If the applicant is a Certified Nurse Midwife (CNM), check one of the provider types listed above and check the box to indicate CNM.
2. **PROVIDER INFORMATION:** All information entered in this section must match the applicant's Medi-Cal record.
 - Legal Name of Applicant: Enter the applicant's legal name used to register the NPI and enroll in Medi-Cal.
 - National Provider Identifier (NPI): Enter the applicant's organizational NPI used to bill Medi-Cal for CPSP services.
 - Doing Business As (DBA) (if applicable): Enter the name under which the applicant conducts business, if different from the legal name.
 - Phone Number: Enter the general phone number to reach CPSP staff, make prenatal appointments, etc.
 - Service Address: Enter the address where applicant will provide CPSP services.
 - Pay-To Address: Enter the address where the applicant wishes to receive pay warrants.
 - Mailing Address: Enter the address where the applicant wishes to receive general correspondence, if different from the service address.
 - Contact Person: Enter the full name, phone number, and email address of the person to contact regarding this CPSP application and other CPSP issues.
3. **SUPERVISION:** CPSP requires that all obstetrical, psychosocial, nutrition, and health education services, and related case coordination be "provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery." (CCR § 51179).
 - Enter the full name, email address, and license number of the physician who will be overseeing all perinatal care, including CPSP services.
4. **CPSP PRACTITIONERS:** List all practitioners who will provide billable CPSP services. For more than 8 practitioners, use CDPH 4448A.
 - A) Practitioner Name: enter the first and last name of practitioner
 - B) Practitioner Type: use only the practitioner abbreviations listed below:
 - MD/DO = Physician specializing in obstetrics and gynecology, family practice, general practice, or pediatrics
 - CNM = Certified Nurse Midwife
 - NP = Nurse Practitioner
 - PA = Physician Assistant
 - LM = Licensed Midwife
 - RN = Registered Nurse
 - LVN = Licensed Vocational Nurse
 - SW = Social Worker
 - PSY = Psychologist
 - MFT = Marriage and Family Therapist (formerly MFCC – Marriage, Family and Child Counselor)
 - RD = Registered Dietitian
 - HE = Health Educator
 - CCE = Certified Childbirth Educator (ASPO/Lamaze, Bradley, or ICEA only)
 - CPHW = Comprehensive Perinatal Health Worker (minimum requirements: at least 18 yrs old, high school diploma or G.E.D., and one year full-time paid practical experience in providing perinatal care)
 - C) Practitioner Qualifications: If applicable, enter the CA license, certificate, or registration number that qualifies the practitioner for the type listed in column 4(B). For all practitioners, enter the name of the school, degree obtained, and year graduated. For CPHWs: enter the name of the high school, "H.S. Diploma" or "GED" for degree, and the year graduated. A Certified Medical Assistant (without at least a high school diploma or GED) does not meet the minimum requirements for CPHW.
 - D) Service(s) Provided: (*choose all that apply*)
 - OB = Clinical obstetrical services (MD/DO, CNM, NP, PA, LM only)
 - B = Backup physician for deliveries (for times when primary delivery physician is not available)
 - CO = Client Orientation
 - HE = Health Education
 - N = Nutrition
 - PSY = Psychosocial
 - CC = Case Coordination
 - CON = Consultation for patients identified as high risk
 - P = Protocol approval
 - E) Years of Experience: Number of years of experience working in maternal and child health as the practitioner type entered in 4(B). For RD enter the number of years of experience in perinatal nutrition.

If using a hospitalist/laborist group for delivery, check the box and enter the name of the group. Individual names of delivery physicians and backup physicians do not need to be listed in Section 4(B). An intrapartum agreement must be included with the application.

If attaching a CDPH 4448A form to include additional practitioners, check the box as indicated.

INSTRUCTIONS FOR COMPLETING THE APPLICATION TO PARTICIPATE IN THE COMPREHENSIVE PERINATAL SERVICES PROGRAM

5. **PROTOCOLS:** Site-specific protocols are due within six months of CPSP approval. Protocols must be approved and signed by qualified health education, nutrition, and psychosocial consultants, and the supervising physician. (see *Title 22 CCR § 51179.9*)
 - Protocols must align with the assessment form used.
 - Providers may develop new protocols or use protocols previously approved within the past five years.
 - If developing new protocols, check the corresponding box and include the qualified health education, nutrition, and psychosocial consultants who will sign protocols for their respective disciplines in the list of CPSP Practitioners (section 4 of the application).
 - If using previously approved protocols, check the corresponding box.
 - Enter the name of the county whose protocols are used and the date those protocols were approved (e.g. “XYZ County – 2017”). If this is an **additional site for the same applicant** and the protocols being used at the previously approved site will also be used at the new site, enter the name of the provider and the date of the most recent protocol update.
 - Indicate the name of the person who is responsible for customizing the protocols for this site.
6. **CPSP PROVIDER OVERVIEW TRAINING:** Identify staff who have attended a state-approved Provider Overview Training (in-person or online). If no staff has attended training, enter the date of the scheduled training staff plans to attend. For information on CPSP training, contact your local PSC or visit the CPSP website (<http://cdph.ca.gov/cpsp>).
7. **ATTACHMENTS:** Attach paper forms or screenshots (if using electronic medical records) and number the required documents as listed:
 - Attachment I: Prenatal Medical Record
 - Attachment II: CPSP Initial Nutrition, Psychosocial, and Health Education Assessment, Trimester Reassessments, and Postpartum Assessment. For nutrition, a dietary intake (e.g. Perinatal Food Group Recall) and current weight grids are also required.
 - Attachment III: Individualized Care Plan – may be a separate document or incorporated into the assessments
 - Attachment IV: General Description of Practice – overview of the practice, describing how obstetrical services (prenatal, delivery, and postpartum) and CPSP health education, nutrition, and psychosocial services will be provided
 - Attachment V: Delivery Hospitals – name(s) and address(es) where deliveries will take place. Delivery MD must have privileges.
 - Attachment VI: Mandated Referral Services - names and addresses of the persons/agencies to whom clients are referred for:
 - Medical Care (Ob and non-Ob)
 - Well-Child Care (e.g. CHDP)
 - Family Planning (e.g. Family PACT)
 - Women, Infants and Children (WIC) Program
 - Genetic Screening
 - Dental Care
 - Attachment VII: Antepartum/Intrapartum/Postpartum and Dual Provider Agreements – an agreement is required any time a provider other than the applicant is providing and billing for any of the antepartum, intrapartum, postpartum, and CPSP services. Contact your PSC for more information and assistance with agreements.
8. **DELIVERIES:** 1) Indicate the approximate number of all deliveries for this site in the past 12 months; 2) enter the number of Medi-Cal deliveries for this site in the last 12 months.
9. **AUTHORIZATION:** Type or print the name and title of the applicant or authorized agent signing the application. Sign and date the application. The person signing the application must have the authority to enter into a contract on behalf of the applicant, e.g. the owner of the practice or the CEO of the clinic.

CPSP PROVIDER APPLICATION CHECKLIST

Please use this checklist to ensure that your CPSP Provider Application is complete prior to submitting it to your local PSC.

Carefully read over the *Instructions for Completing the CPSP Provider Application* and review the CPSP regulations.

Complete the *CPSP Provider Application* (CDPH 4448).

Attach the *Perinatal Medical Record Form(s)* (Attachment I).

Attach the *Nutrition, Psychosocial, and Health Education Assessment Tools* (Attachment II).

Attach the *Individualized Care Plan Form* if separate from the assessment tool (Attachment III).

Attach the *General Description of Practice* (Attachment IV).

Attach the list of *Delivery Hospitals* (Attachment V).

Attach the list of *Referral Services* (Attachment VI).

Attach the *Antepartum/Intrapartum/Postpartum Agreement(s)*, if applicable (Attachment VII).

Sign and date the application.

Submit the completed application to your local PSC.